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Notice of Independent Review Decision

April 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Glasses with therapeutic lenses

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Fellow American Academy of Ophthalmology
Certified by the American Osteopathic Board of Ophthalmology
American Society of Cataract and Refractive Surgery
Member American College of Eye Surgeons – Houston Ophthalmological Society

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had complaints of bilateral blurred vision, double vision, dizziness and throbbing headaches that started from a motor vehicle accident (MVA) in xx/xxxx.

On July 9, 2014, performed a dental peer review. His opinions were: (1) The films and photographs taken were appropriate for the proper diagnosis of oral disease/condition and anticipated resolution and/or restoration. (2) Based on treatment plan submitted by the attending dentist, the tertiary treatment (replacement of upper full dentures and lower partial denture) was reasonable and necessary since the patient's prosthesis were lost in the accident. (3) The over-attention to the periodontal status of the patient in relation to the proposed lower partial design was not reasonable or essentially necessary to address the injury

complaint, which were the lost dentures. (4) A preliminary debridement and prophylaxis would be a more reasonable approach for success of a flexible base partial denture. (5) Enhancements of upper jaw in case the "upper denture is not satisfactory due to lack of bone" should be considered elective care and was not related to the claimed injury. Incidentally, no documented tooth loss occurred as a result of this accident. The following additional records were reviewed: *"On June 19, 2014, evaluated the patient and noted the patient was involved in an MVA on xx/xx/xx, and lost his upper dentures and lower partial dentures. Dental x-rays were obtained. recommended scaling LL/LR, complete upper dentures, ValPlast partial on lower and 16 Arestins. If the upper dentures were no satisfactory due to lack of bone, then consider bone augmentation and implant supported dentures. Claim note from July 2, 2014, revealed the patient was asleep in the bunk when the driver lost control and rolled the whole unit twice. The patient received injuries to face, back, legs and ribs. The patient was initially transferred to Utah Valley Regional Hospital and was in intensive care unit (ICU) for 10 days. He was transferred to rehab facility on May 13, 2014, and diagnosed with left lower leg degloving injury (I&D performed on May 1, 2014), left thigh road rash, superficial and deep tissue abrasions, right foot partial-thickness burn injury, fracture left 6 through 11 ribs with two fracture visible in 8-10 ribs, left pneumothorax, T12 compression fracture spine, facial fracture frontal sinus extending into nasal bone and orbit, left spinal transverse process fracture of L1-L4, laceration of lips, face and scalp; multiple abrasions and contusion."*

On September 3, 2014, evaluated the patient for complaints of constant blurred vision bilaterally, double vision, dizziness and throbbing headaches. He also reported the print appeared to move when reading and he loses place when reading/tracking. The patient reported occasionally he would find distance more than near that would last a few hours. He would take naps that helped. This all started from the MVA. He reported occasional dizziness as couple of times a day that lasted a couple of minutes to sometimes an hour. Medications would help. The headaches were occasional three to four times a day rating it at 9/10 in severity. The patient had a history of traumatic brain injury (TBI) from an MVA, muscle pain, joint pain, headaches and seizures. He currently wore glasses. His last eye examination was a month earlier. His habitual spectacles were OD and OS +0.00, Add +2.50. Auto refraction was OD – 2.25 -1.25 145 and OS – 0.25 -1.0 120. Near point auto refraction was OD-2.5D/40 cm, OS-4D/25 cm. The Ishihara color vision test, Steropsis test and Tonometry was normal. Cover test revealed right hypertropia to distance and right hypertropia with exophoria component to near. He was tested up to 9 field of gaze. Extraocular motility revealed diplopia, pain and restriction. Pursuits showed 3-4+ jerky movements/fixation loss. Saccades revealed 2-3+ jerky movements/body movements/undershoots. No nystagmus was noted. Saladin Phoria testing revealed vertical 2 right hyper in all 9 gazes and 2 exo in all 9 gazes. Manifest refraction was OD: PL VA 20/25 and OS: -0.25 VA 20/20. Horizontal Fusional ranges revealed near lateral Phoria 6exo and suppression with near vertical Phoria, near base In/out. NRA was +1.50 and PRA was -1.75. Therapeutic prism acceptance revealed 2 and 3 BD. The patient felt comfortable to look at the paper. Pupils were equal, round and reactive to light and accommodation in both

eyes. assessed convergence insufficiency, oculomotor dysfunction and dizziness. The patient was recommended neurosensory testing and dilatation testing.

On October 1, 2014, the patient underwent neurosensory testing and dilatation testing.

On October 14, 2014, the patient underwent neuro-optometric vision assessment for assessment of visual tracking, visual teaming, visual focusing, visual-spatial awareness and general visual health. It was found the patient had mild age-related cataracts in both eyes that could cause glare. This was to be observed on a yearly basis. He had 20/20 acuity and had ability to see the 20/20 lines at reading distance. prescribed therapeutic (neural) lenses to expand vision space thereby improving visual attention, decreasing stress on focusing, allowing better convergence and improving visual attention.

Per a utilization review dated January 30, 2015, the request for DME – glasses with therapeutic lenses was denied with the following rationale: *"Per the convergenceinsuMiciency.org, "A multi-site randomized clinical trial funded by the National Eye Institute has proven that the best treatment for convergence insufficiency is supervised vision therapy in a clinical office with home reinforcement (15 minutes of prescribed vision exercises done in the home five days per week). The scientific study showed that children responded quickly to this treatment protocol; 75% achieved either full correction of their vision or saw marked improvements within 12 weeks." Orthoptic eye exercises can help correct intermittent exotropia with convergence insufficiency. The patient has not failed orthoptic eye exercises or other conservative care. Therefore, the request is not certified."*

Per a letter of medical necessity dated February 10, 2015, noted the patient was under his care for comprehensive Neuro-Optometric Rehabilitation and felt he suffered from convergence insufficiency or palsy, dizziness and giddiness, and nonspecific abnormal oculomotor studies. The treatment included use of lenses and/or prism to remediate the visual process. The patient was prescribed a combination of lenses and prisms in combination to improve his symptoms to restore visual function. Unfortunately, the carrier denied the use of therapeutic lenses. The failure to treat his condition would risk continued poor visual, functional and occupational performance propagating his visual disability.

Per a reconsideration review dated February 18, 2015, the request for appeal for glasses with therapeutic lenses was denied with the following rationale: *"ODG does not address the requested therapeutic lenses. Aetna states, "An initial pair of contact lenses or eyeglasses is considered medically necessary under medical plans when they are prescribed by a physician to correct a change in vision directly resulting from an accidental bodily injury." The specific lens requested is not known. There are no studies in the medical literature that special lenses for patient with subjective complaints of blurred or double vision without any abnormalities on examination are effective. Therefore, the request is not certified."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
I have reviewed all records provided. The claimant suffered closed head trauma due to an MVA on May 1, 2014. Subsequently, he complained of double vision and has been appropriately evaluated. He was found to have convergence abnormality with an associated vertical (hypertropia) imbalance. No other ocular abnormalities were discovered that were compensable.

After exhaustive testing it was found that with appropriate prism correction in a spectacle, the claimant was more comfortable and able to fuse. His headaches abated and reading became more effective. In my experience of over 40 years the use of prism correction in these particular cases (closed head trauma) is a better solution. The application of exercises and orthoptic therapy are more successful in the pediatric patient. Further, I noted vertical prisms were also advised (2-3 base down prism diopters). The delicate balance that allows fusional ability can most definitely be upset by the injury as described.

Although the peer reviewer sited the use of ocular muscle exercises, an individual suffering closed head trauma is better served by the use of prism therapy as this allows a quicker recovery and resumption of normal life. Exercises and other vision training techniques are much more time consuming and more expensive. The prism correction may not permanently correct the problem (and so it is w/ vision training), but it allows the claimant to return to a more normal life (and gainful employment) more quickly.

An eyeglass prescribed herein is therefore, a medical necessity and, in my opinion, is a compensable expense. The claimant will need to be re-evaluated periodically to assess his diplopic issue(s).

I have reviewed the Aetna criteria and found they are deficient in not addressing the visual complaint per the claimant and provider. I, therefore, am relying on my 4 decades of clinical experience and expertise in arriving at this decision.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **AETNA CRITERIA**

☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**